Workforce and Skills Assessment Summary

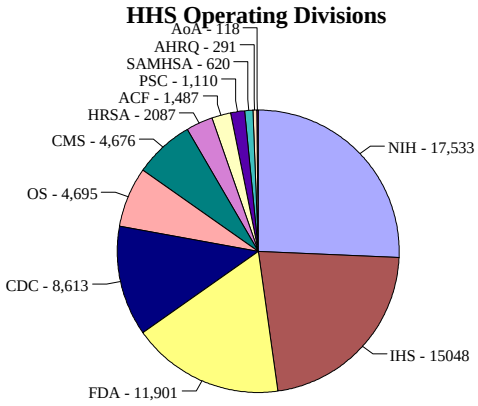
Department of Health and Human Services

June 2001

Workforce Summary

The Department of Health and Human Services is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS carries out its mission through more than 300 programs, covering a wide spectrum of activities, ranging from medical and social science research to disease prevention, health promotion, substance abuse prevention and treatment, child support enforcement, Medicare, Medicaid, and services for older Americans.

HHS is made up of 12 Operating Divisions, ranging in size from the National Institutes of Health with over 17,000 employees to the Administration on Aging with fewer than 120. The four largest Operating Divisions – the National Institutes of Health, the Indian Health Service, the Food and Drug Administration and the Centers for Disease Control and Prevention – make up 78 percent of the HHS workforce.



Since his arrival, Secretary Thompson has emphasized that HHS is one department, unified by a shared mission and goal to serve the American people. Several efforts are underway that implement this approach to managing HHS. These include developing a unified financial management system, finding better ways to economize through group purchases, and achieving greater advances in information technology through an Enterprise Infrastructure Management approach. In addition we are continuing our efforts to implement a department-wide Enterprise Human Resources and Payroll system to address core personnel functions. Efforts are underway to consolidate administrative functions in the Office of the Secretary and to consolidate servicing personnel offices, with the goal of eliminating duplication of offices and functions.

Overview

At the end of fiscal year 2000, HHS had a total of 68,179 employees. Of this total, 57,500 (84 percent) were permanent. The permanent staff has two major components. One is regular civilian employment, which includes general schedule employees (GS and GM), Senior Executive Service, and a small number of blue collar employees. The second is the Public Health Service Commissioned Corps. In September 2000 HHS permanent employment included 4,713 officers

in the Commissioned Corps. The Commissioned Corps is an all-officer uniformed service of health professionals – largely doctors and nurses. As a uniformed service, the Commissioned Corps is not included in the Central Personnel Data File. Corps members are employed in all the health agencies of HHS, including small numbers in the Office of Public Health and Science in the Office of the Secretary and the Centers for Medicare and Medicaid Services. They provide direct patient care to Native Americans and Alaska Natives at Indian Health Service facilities and are key elements in the staffing of the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention and the Health Resources and Services Administration.

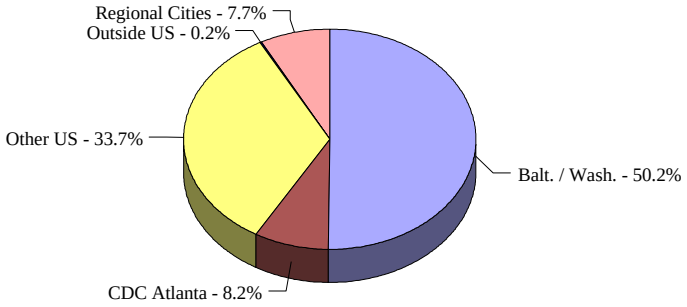
The non-permanent HHS workforce of 10,600 employees is made up of several distinct groups. One group is the 2,700 clinical fellows under the Public Health Service Act. These are post-doctoral scientists who are being trained as clinical research scientists. At the end of the training period some are converted to permanent appointments, the remainder continue their research careers in the extramural research community, working in hospitals, foundations, and university settings. The clinical fellows program serves as a means for building extramural research capacity, strengthening the nation's overall biomedical research community.

Experts, consultants, and advisory committee members are a second part of HHS's non-permanent workforce. In this group of over 4,400 employees, fewer than 200 experts work full time. The remainder work intermittently, either as consultants or members of programmatically-oriented scientific advisory committees. These advisory committee members swell the total employment of HHS, but since they work only a few days each year, they do not consume significant amounts of ceiling. This group is the reason that total employment in HHS is several thousand higher than the paid employment in any given month.

The remainder of the non-permanent workforce, about 2,800, are mostly students, with a small number of true temporary employees – staff hired to meet short-term needs. There are some indications that this trend is changing, as the Indian Health Service has increasingly turned to temporary appointments to meet patient care needs in fiscal year 2000.

Geographical Location

The HHS workforce is heavily centered on headquarters operations in the Baltimore / Washington area and in Atlanta, location of the Centers for Disease Control and Prevention (CDC). A relatively small number of employees work in the ten Regional Office cities (Boston, New York, Philadelphia, Atlanta, Chicago, Dallas,



Kansas City, Denver, San Francisco, and Seattle). Only two components of HHS have field structures: the Indian Health Service and the Food and Drug Administration. The Indian Health Service field structure includes over 550 hospitals, health centers, health stations, satellite clinics, and Alaska village clinics.

Workforce Demographics

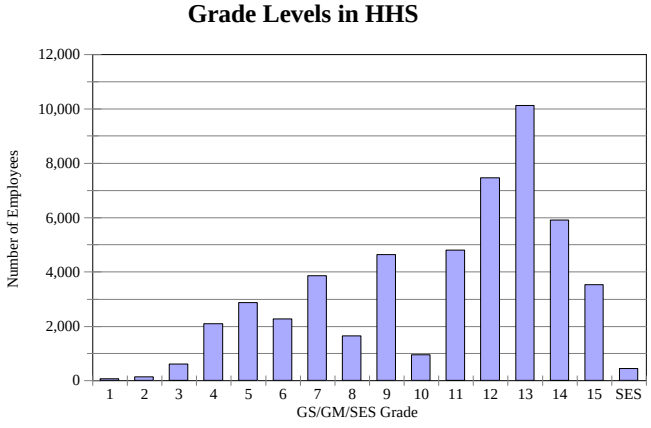
HHS has a highly-educated, highly skilled workforce. Over 40% of HHS employees are in professional positions – jobs which require specific education, such as doctors, nurses, and Ph.D.-level researchers. Another 30% are in white-collar administrative jobs. Fourteen percent are in technical jobs – most of them medical technicians – which require specialized training. The remainder includes clerical support staff and a small number of blue collar employees helping to maintain medical facilities.

Occupation	Percent
Health / Scientific	
Nurse	6.4%
Medical Officer	6.0%
Health Scientist	4.7%
Biologist	3.7%
Consumer Safety (FDA)	3.1%
Chemist	2.9%
Public Health Analyst	2.6%
Microbiologist	1.9%
Human Services	
Health Insurance (CMS)	3.2%
Social Science Analyst	1.8%
Administration / Analysis	
General Administration	4.1%
Computer Programmer / Analyst	3.8%
Program Analyst	3.6%
Support	
Secretary	4.2%
Clerk	4.1%

Over 300 occupations are represented in the HHS workforce, but only fourteen have over 1,000 employees. Together these fourteen occupations make up more than 56 percent of the HHS workforce, and constitute the main occupations of the department. Table 1 shows these fourteen occupations grouped into four categories: medical/scientific; program management; analysis/administration; and support. The eight medical/scientific occupations shown here by themselves make up over 31 percent of the HHS workforce. This is by no means the entirety of the HHS medical / scientific workforce, but it does point up the predominance of HHS's health mission.

In addition to being large components of the HHS workforce, these occupations are generally cross-cutting, showing up as major occupations in multiple components. Two occupations that are not cross-cutting, Consumer Safety and Health Insurance, are single agency occupations, specific to the Food and Drug Administration and the Centers for Medicare and Medicaid Services, respectively.

Grade Levels

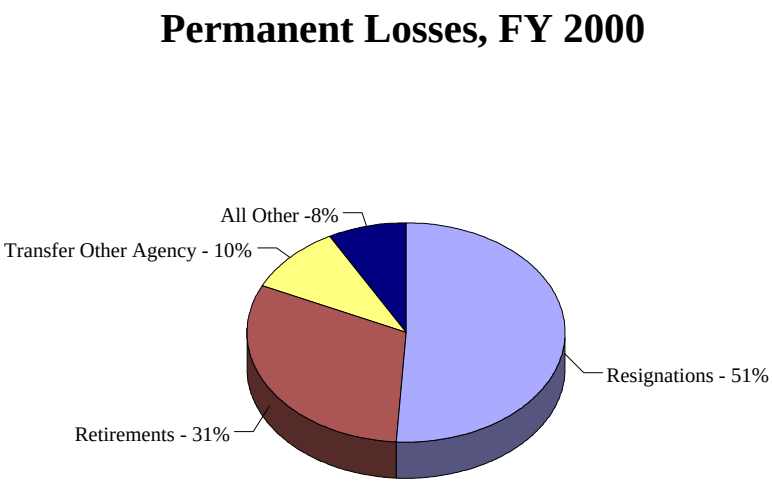


The average GS grade in HHS is 10.6, compared to a government-wide average grade of 9.6. The HHS average grade reflects several factors which influence the workforce. One is the large number of highly educated health

professionals. Their higher grades raise the average grade of the workforce. A second factor is a long period in which we have had little ongoing entry-level recruiting. Simply put, in many cases the pipeline from entry-level to the journeyman level is empty. For the most part, the mid-level GS employees are employees at the journeyman level for their jobs, and are not on track for future management positions. This points up the need for ongoing stable recruitment efforts to assure that we will have staff ready and able to move upward over the course of the next few years.

Turnover

Turnover in all its forms – mainly retirements, resignations, and transfers to other agencies – has an ongoing impact on the skills needed in the workforce.



Attention has tended to focus on the impact of anticipated retirements as increasing numbers of employees become eligible to retire. Retirement is only one part of the larger turnover picture, and is not that largest contributor to turnover.

As the pie chart of permanent losses in HHS for fiscal year 2000 shows, just over half the Department's 3,670 permanent losses were due to resignations. Retirements in FY 2000 accounted for 31 percent of total losses; transfers to agencies outside HHS were another 10 percent, and all other causes were the other eight percent.

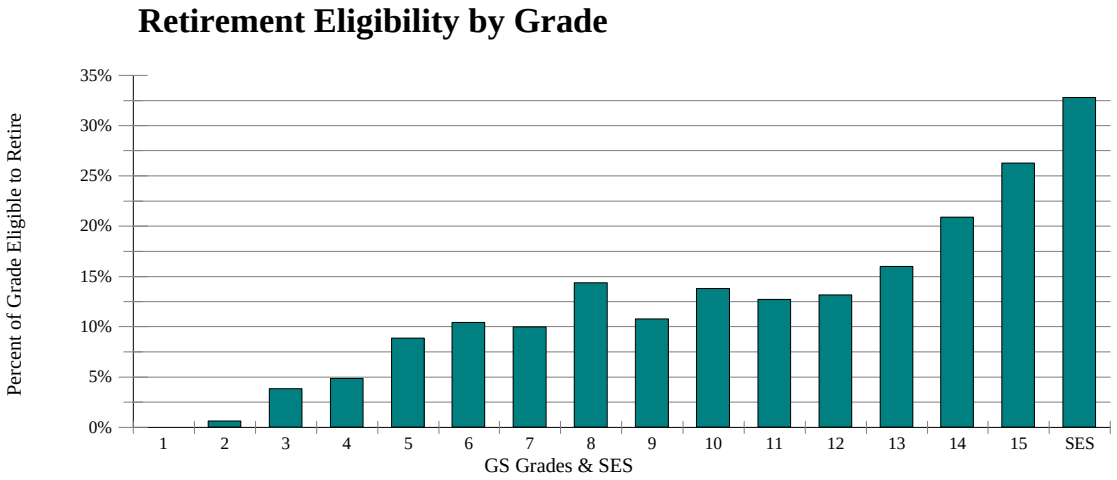
Looking at resignations provides some clear indications of their impact on the workforce. The largest number of permanent resignations in FY 2000 were among nurses, one of HHS's most populous occupations. While nurses are 6.4% of the workforce, they accounted for 14% of the resignations. This loss rate is an issue that needs attention, since it directly affects mission accomplishment. Employees who resigned in FY 2000 averaged 38 years old with just over six years of service. This age and service profile suggests that we are not hiring exclusively from recent graduates, but hiring people with experience who then spend only a portion of their careers with the federal government.

We believe this is a pattern that employment will follow in the future. Federal government career patterns for the “baby boom” generation have included large numbers of employees who have worked continuously for the government for 30 years or more. Younger generations, a strong economy, and changing values make it likely that this pattern will be replaced by one in which there is greater movement among the Federal government, private industry, and the non-profit sector. Greater career mobility was a stated purpose in the design of the Federal Employees Retirement System (FERS) in the mid-1980s, which replaced the Civil Service Retirement System (CSRS). The plan’s designers expected that basing FERS on Social Security coverage would make it more likely employees would move between the federal and private sectors.

However, the large percentage of permanent losses coming through resignation makes it important that we take steps to retain employees. Otherwise the federal government as a whole faces the prospect of increased recruitment overhead if we wind up filling and re-filling the same positions over and over again. This puts a premium on our ability not just to recruit people with the right skills, but to keep them once we have hired them. Examples of our efforts to are discussed in the skills assessment section of this report (page 13).

Age and Retirement

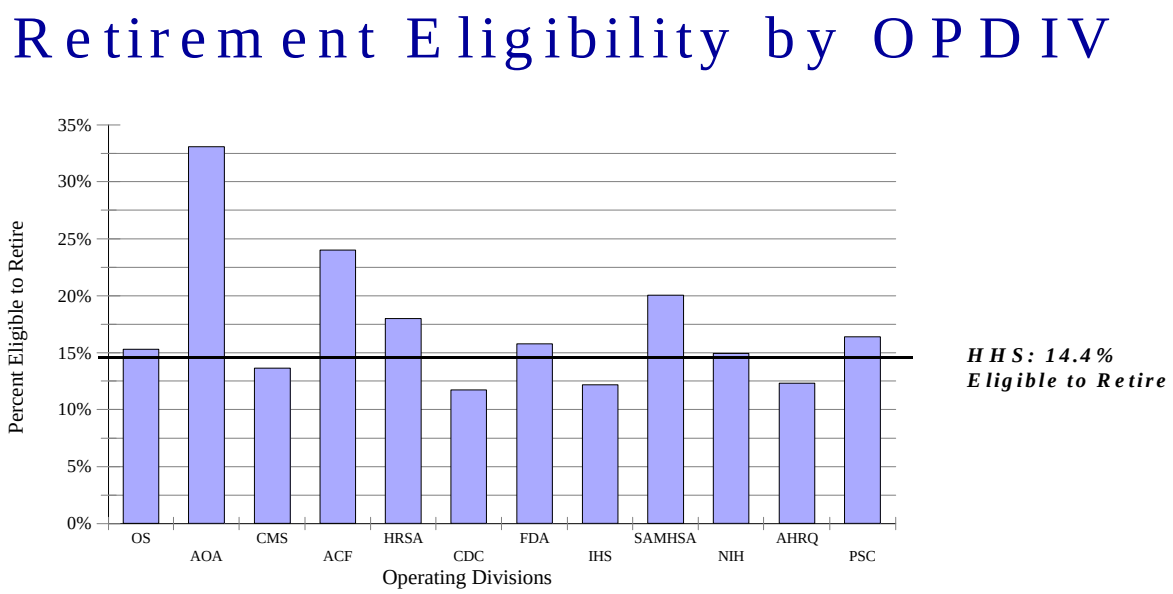
Like other federal agencies, HHS is facing the challenges of an aging workforce. The permanent workforce at HHS averages 46.02 years of age. Among the most common occupations in HHS, this figure varies only slightly, ranging from a low of 45.97 for nurses to a high of 50.73 for social science analysts. All of this points up a cross-cutting concern with the impact of coming retirements.



While the average age range is constant across many of the major occupations, it shows significant variances in other ways. The graph of retirement eligibility by GS grade shows

emphatically how average age rises as GS grade increases. With advancement weighted toward longevity and experience, this is no surprise, but it underlines the fact that we can expect retirements to be weighted toward higher-graded employees. We can expect this to have mixed effects. Retirements of higher-graded employees and executives will impact on institutional knowledge, but at the same time should also provide some opportunity for delayering, as well as advancement opportunities for some junior staff.

As the graph of age by GS grade suggests, a significant number of HHS employees are eligible



to retire, and more will reach eligibility in the next few years. We expect retirement to impact on all the HHS Operating Divisions, but the effects will be more severe in some organizations than in others.

Two components of HHS, the Administration on Aging and the Administration for Children and Families, have retirement eligibility levels well above the Department as a whole. Three others, the Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, and the Program Support Center have retirement eligibility levels that warrant attention. These are five of the six smallest HHS components; the impact of impending retirements in these organizations could be disproportionate to the actual numbers of retirees. However, workforce plans are taking projected retirements into account.

The tables on the following pages show projected retirement eligibility for civilian staff through 2005, both by Operating Division and for the most populous occupations. It should be noted that

the most common occupations in HHS also have the most employees who will be eligible to retire.

Being eligible to retire is not the same as actually retiring. There are many methods of forecasting retirements. The most accurate are those based on applying past patterns to the future. The retirement forecasts shown here are based on an analysis of five years of data on retirements, examining the number of days retirees worked between the time they become eligible to retire and the date they actually retired. The analysis shows that ten percent of employees retire within two months of becoming eligible; a quarter are gone in one year. Half of all employees retire within three years of reaching eligibility. Using this data, it is possible to make projections that are based firmly in past experience.

Retirement Eligibility by Operating Division Through 2005
(Does Not Include Commissioned Corps)

			Will become eligible in					
	Employees Covered by Retirement	**Eligible by Dec. 2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**Total**
OS	2,978	429	100	105	123	117	103	977
AOA	117	40	9	8	13	6	2	78

CMS	4,430	560	219	254	272	238	221	1,764
ACF	1,449	315	102	94	116	104	75	806
HRSA	1,621	288	69	97	62	90	55	661
CDC / ATSDR	7,174	785	215	287	259	317	283	2,146
FDA	8,576	1,276	314	349	353	443	385	3,120
IHS	12,544	1,407	427	437	445	485	503	3,704
SAMHSA	513	98	35	36	30	35	25	259
NIH	15,533	2,212	501	558	547	553	518	4,889

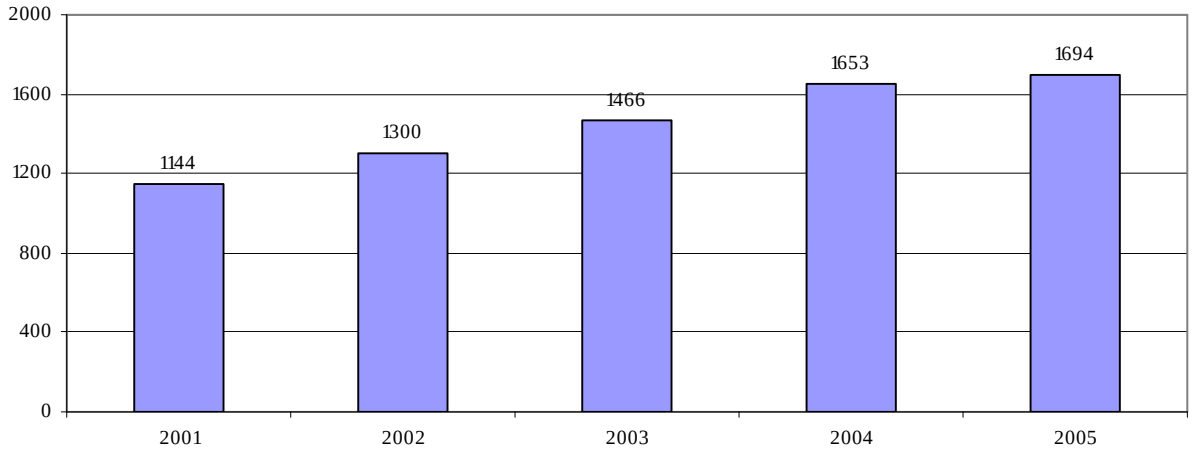
AHRQ	251	30	14	10	13	11	11	89
PSC	1,031	155	42	44	55	52	47	395
Total	56,217	7,595	2,047	2,279	2,288	2,451	2,228	18,888

The number of employees reaching retirement eligibility rises steadily through 2004. This rise is typical of the increased eligibility that several studies have noted government-wide.

From 1996 through 2000, HHS averaged just under 1,000 voluntary retirements per year. Based on experience, the increasing numbers of employees becoming eligible each year will translate into an increasing number of retirements annually. Retirements will not equal eligibility, but the increase in eligible employees will produce an increase in the number of actual retirements.

Retirement Eligibility in Most Common Occupations Through 2005 (Does Not Include Commissioned Corps)								
			Will become eligible in					
Occupation	**Employees Covered by Retirement**	**Eligible by Dec. 2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**Total**
Nurse	3,405	399	123	122	127	129	126	1,026
General Admin.	2,454	366	108	106	126	109	103	918
Chemist	1,784	429	88	83	81	90	73	844
Health Scientist	2,018	356	93	90	88	103	95	825
Program Analyst	2,260	330	84	125	110	90	83	822
Secretary	2,683	327	83	98	91	81	102	782
Health Insurance	1,968	252	91	108	130	107	93	781
Computer Program /Analyst	2,390	253	95	96	93	136	88	761
Consumer Safety	1,810	234	71	77	77	134	98	691
Medical Officer	2,404	316	59	71	61	91	68	666
Public Health Analyst	1,538	255	57	73	72	90	70	617
Clerk	2,418	243	61	80	71	70	77	602
Social Science Analyst	1,088	235	64	77	79	67	56	578
Biologist	2,196	195	47	55	59	51	53	460
	30,416	4,190	1,124	1,261	1,265	1,348	1,185	10,373

Projected Retirements, 2001 - 2005



Based on the numbers of people eligible and analysis of past experience, we anticipate that voluntary retirements in fiscal year 2001 will rise to about 1,144. Following the increase in eligibles, voluntary retirements can be expected to rise to 1,300 in 2002; 1,466 in 2003; 1,653 in 2004; and top out at 1,694 in 2005. Actual retirements will total 7,250 over the next five years, an average of 1,450 per year. In the first half of FY 2001 we have had 530 retirements, less than half the expected total for the year.

Supervisory Ratios

The ratio of supervisors to total staff in HHS is 1 to 8.3, a noticeable change from the 1993 ratio of 1 to 5.5. While this ratio provides a numeric measure of the workforce, it ignores any measure of whether the staff has the skills needed. A more appropriate measure is the quality of service delivery, not an internal workforce comparison of supervisors to staff.

Budgeting to performance requires that we identify the correct performance to measure. Providing service is the correct measure: quality, timely, and efficient service. Workforce planning depends not just on the right number of employees but having employees with the right skills.

In addition, issues such as mission and geographical distribution of employees impact on supervisory ratio. The Indian Health Service, for example, operates 550 hospitals, health centers, health stations, satellite clinics, and Alaska village clinics. Small clinics may have only four or five staff, one of whom is a supervisor. Because of their geographic dispersion, these clinics will affect supervisory ratios while not affording a realistic opportunity for changing the ratio.

In a clinical research setting, one senior scientist may supervise a relatively small number of researchers. The mission in this case, clinical research, does not lend itself to broad spans of control. The subject matter focus of research requires expertise in scientific oversight and supervision, again offering little opportunity for changing supervisory ratios.

Skills Assessment Summary

The skills assessments conducted by the HHS Operating Divisions, both for this initiative and for ongoing workforce planning, have developed a significant amount of information on workforce skills – both present skills and those that are needed in the future. There are cross-cutting skills relating to health program management and to general management and analysis that emerge from the assessment. This report provides a summary and synthesis of the skills assessments carried out in HHS.

Improving human capital management is an aspect of workforce planning that Secretary Thompson has made a priority at HHS. He also has a keen interest in improving our recruitment and retention strategies and pursuing additional personnel flexibilties to help meet the Department's future workforce needs. Attached to this report is a letter from the Secretary to the Chairman of the Subcommittee on Oversight of Government Management, Restructuring and the District of Columbia, Senate Committee on Governmental Affairs, expressing the importance he places on workforce issues.

1. What skills are currently essential to the accomplishment of the agency's goals and objectives?

Using a variety of methods the HHS Operating Divisions identified skills essential to mission accomplishment. The skill sets are remarkably consistent across the Department, although there are variations in how skills are described. The overall skills can be divided into two sets: medical / scientific skills and program administration skills.

Medical / scientific skills cut across all the Health Operating Divisions. Examples include:

- Research
- Laboratory skills
- Testing and evaluation
- Statistical and Mathematical skills
- Medical / Scientific analysis
- Clinical Testing
- Patient care

Program administration skills cut across the entire Department. These skills include:

- Program administration
- Program analysis
- Planning
- Communication
- Budgeting

- Financial management
- Policy development
- Program monitoring
- Contractor management
- Grants management
- Management / Leadership
- Information Technology
- Change management

It should be noted that these two broad skill areas are not completely distinct. Information technology skills, to take one example, are vital to program management but may also be critical to successful evaluation of clinical trials and patient care studies. In addition, many of these skills can be sub-divided into more discrete knowledge areas. The wide range of specialized knowledge that is needed in the workforce impacts on how skills are described in different organizations, particularly in the medical and scientific fields. While the specialized knowledge needed varies by program, the clinical, medical, and research skills cut across program lines.

In addition, change management skills cut across lines. In order to effectively implement changes in how we do business we need planning skills, organizational analysis skills, financial cost accounting skills, and other skills related to business process re-engineering. This set of skills cuts is necessary to all of our efforts to flatten organizations and restructure the workforce to provide more effective, results-oriented government.

2. *What changes are expected in the work of the agency (e.g. due to changes in mission/goals, technology, new/terminated programs or functions, and shifts to contracting out)? How will this affect the agency's human resources? What skills will no longer be required, and what new skills will the agency need in the next five years?*

We expect that changes in how services are delivered and how programs are managed will be the major drivers of changes in what skills HHS employees need. We expect that the President's Management Plan and HHS initiatives such as a unified financial management system and efforts to consolidate administrative functions will affect both our skills needs and the shape of our workforce.

In some cases, such as the Centers for Medicare and Medicaid Services, skills mixes may be affected by legislative changes in mission. For example, CMS projects that adding a prescription drug benefit to the Medicare program would increase their need for pharmacological skills. CMS has also assessed workforce skills needed to more effectively deliver services and manage their business operations. These skills areas are: management / leadership; financial management; contractor management, medical and clinical; information technology; and communication. Health-related skills will be affected by new and different ways of delivering services. For example, the Indian Health Service is exploring the use of telemedicine – doctor and patient brought together by video – as a means of delivering health care to remote sites. This will require more and different communications skills to interact with patients and provide care.

The globalization of public health programs such as immunization, infectious diseases (AIDS, Tuberculosis, Hepatitis A/B/C, *etc*.) and food borne diseases (*e.g*. "mad cow" disease) will increase the need for epidemiologists and public health scientists with skills to work and function in other parts of the world and different cultures. New skills will be needed to work across cultures, providing public health services and information.

In administrative areas, we expect to have some skill surpluses as a result of several efforts to consolidate functions to achieve greater economies of scale, eliminate duplication, and provide better service delivery. We are consolidating administrative functions in the Office of the Secretary, a move which will mean that instead of each Staff Division having its own administrative office, one administrative office will serve all. This will provide economy of scale and allow us to redirect staff resources toward accomplishing the department's mission.

We are establishing a unified financial management system for the Department. This will consolidate multiple accounting systems into a single system for HHS plus a modern accounting system for CMS and its Medicare contractors. We expect this to provide economies of scale, as well as providing better delivery of financial services. This system is in accord with the HHS information technology direction, which establishes an enterprise approach for IT in HHS, providing greater commonality of software and platforms for HHS systems.

Overall efforts to flatten organizations, de-layer, and consolidate administrative functions will require effective change management skills, as noted earlier. The skills to carry out business process re-engineering are fundamental to restructuring.

Several other initiatives will affect the skills we will need.

- Increased contracting of functions that are not inherently governmental will require improved or broader skills in competitive contracting, cost analysis, program analysis, and financial management. This need cuts across the Department and program areas.

- Strategic management of human capital will require us to improve skills in internal consulting. The human resources community will need to communicate better with managers and develop stronger customer service skills. With a focus on finding and keeping the right people, there will be a need for stronger human resources analytical skills and information technology skills for recruiting, developing, and retaining employees.

- Financial Management is recognized as a critical skill or "essential competency" across HHS. The skills and abilities needed to improve financial management are:

    - Analytical skills (*e.g*., the ability to analyze financial systems and systems designs).

- < IT skills (*e.g.*, the ability to understand systems connectivity issues, use software for analytic purposes, etc.).
- < Accounting skills (*e.g.*, knowledge of requirements of CFO Act, GMRA, and FFMIA).
- < Budget formulation skills (*e.g.*, the ability to propose and defend budget requests).
- < Budget execution skills (*e.g.*, the knowledge of requirements of appropriations. law).
- < Ability to communicate logically, both orally and in writing.
- < Ability to negotiate.
- < Ability to work on several major, interconnected issues and understand the relationship to the overall mission.
- < Ability to derive program cost information for decision-making. This requires an understanding of performance measurement, programs, the systems which can capture results information, and cost accounting principles.

C Expanding electronic government will require greater information technology skills across the workforce, not merely among information technology workers. Implementing e-government systems means that program staff must have increased skills to understand system operations. Program staff must also have increased systems analysis skills to effectively participate in systems design and development.

The need for broader and greater Information Technology (IT) skills goes beyond the initiative to expand electronic government and cuts across initiatives. Improved IT skills will be needed not just among IT staff but in non-IT functions which use automated systems. Automation has significantly changed the way in which all offices carry out their work. These changes will continue. In some cases the workforce has not kept pace with changes in skills and work processes. As processes change, we need to make sure that our workforce has the skills to use new systems and new technology.

3. What recruitment, training, and retention strategies are being implemented to help ensure that the agency has, and will continue to have, a high-quality, diverse workforce?

HHS is pursuing several strategies aimed at making sure that we can compete for the workforce we will need.

We are implementing automated processes for accepting, rating, and ranking applications, speeding up the decision-making process to make us more competitive with private sector companies who have the ability to make job offers on the spot. We expect this will be integrated with the Department’s new personnel / payroll system now in development.

HHS as a whole and several of the OPDIVs in particular are making significant investments in the training and development of employees. The Department has implemented its distance learning site on the internet, allowing employees to establish learning accounts and take courses

on-line at their convenience. This provides employees with access to hundreds of courses to learn new skills to improve current job performance and to prepare for future responsibilities.

The Centers for Disease Control and Prevention has established the CDC Corporate University, an agency-wide strategic initiative to systematically provide organizational and employee development in direct support of CDC and ATSDR's mission, vision, values, culture and strategic goals. The Corporate University structure, allows CDC to respond quickly and effectively to needs for Certification Programs, Career and Intern Development Programs, and college credit courses. Examples include a 3-year Financial Management Certificate Program; a 2-year Public Health Administrative Specialist Certificate Program; a Masters in Public Health program via satellite downlink from the University of South Florida; and various collaborations with colleges and universities. Self-guided web-based instruction was successfully piloted and implemented through the CDC CU.

The Food and Drug Administration plans to expand the FDA University and Staff College educational activities. The FDA University provides opportunities to scientific staff to maintain their professional development – an important retention tool. Collaborating with universities and other academic institutions provides opportunities to establish curriculum that is directly related to FDA's scientific needs. It will also provide the opportunity to interact with graduates and undergraduates and get them interested in coming to work at FDA.

HHS is also looking at ways in which we can coordinate recruiting activities across the Department to increase efficiency, make the best use of recruiting resources, and spread a broad net to find and recruit new talent.

Another means of improving our competitive position in the recruiting market is through efforts to better explain the total compensation connected with a federal job. The charge is made frequently that federal government salaries can not compete with the private sector for certain occupations. While that is true in some instances, explaining the federal benefits package in plain English can provide some competitive edge in return. Because of its size, the federal government can provide more health benefits options than most private sector companies. In addition, we offer life insurance; a stable retirement system; the Thrift Saving Plan; generous holiday, vacation and sick leave; transit benefits; child care subsidies; student loan repayment; and the opportunity to take part in telework.

4. How is the agency addressing expected skill imbalances due to attrition, including retirements over the next five years?

Many of the strategies being used to recruit and retain our future workforce apply to our efforts to address potential skills imbalances as well. As business processes change, training will provide employees with the skills needed to use new systems and new technology.

In medical and scientific areas the largest medical and scientific OPDIVS – NIH, FDA, and CDC – are providing training and education opportunities to keep scientific skills up-to-date. In the

larger OPDIVs, such as NIH, corporate recruiting programs are integrating skills develop and outside recruiting to address skills imbalances through the combined efforts of training and outside hiring.

However, in order to effectively address skills imbalances, we must know what those imbalances will be, and what causes them. HHS has been addressing this issue through a concerted effort to foster workforce planning across the Department. The HHS workforce planning guide is available on the internet at http://www.hhs.gov/ohr/workforce/wfpguide.html. The workforce planning guide was published in 1999, and serves as the Department's resource guide for carrying out workforce planning.

The supply analysis and demand analysis aspects of workforce planning provide the information needed to accurately identify skills gaps – both positive and negative. Knowing potential skills shortages and surpluses allows us to make use of training to help close skills gaps and reposition employees to areas in which more help is needed, as well as to target recruiting in the short and longer-terms to addressing the gaps.

5. What challenges impede the agency's ability to recruit and retain a high-quality, diverse workforce?

There are several cross-cutting issues which impede our ability to compete for, recruit, and retain the high-quality, diverse workforce we need.

We need to address the overall slowness of human resources processes, particularly the recruiting and examining process. As noted in our response to question 3, when personnel processes make it weeks before a manager can select a candidate, it is difficult to compete with an employer who can make an offer immediately. Part of this can be offset by improving processes – electronic receipt of resumes, rating and ranking can help but will not make all the difference needed.

Several statutory and regulatory changes to civil service processes are needed to allow the federal government to effectively compete in the labor market. The areas to be addressed and the changes needed are:

- *Entry-level Hiring*: We must even the playing field with private-sector recruiters by having the ability to make on-the-spot offers at job fairs and colleges. For entry-level and hard-to-fill occupations, where the minimum qualifications are straightforward (e.g., undergraduate/graduate degrees), recruiters must be able to make selections and job offers immediately.

- *Rule of Three*: The rule of three, a long-standing barrier, restricts selection from a list of eligible candidates. There are better ways of ranking and referring candidates which allow managers greater flexibility in making decisions without abridging merit principles.

- *Broad-banding*: Broad-banding pay systems have been tested extensively in demonstration projects and offer a number of benefits: more flexibility in pay setting; greatly reduced classification workload, and easier linkage for pay-for performance. Concerns about pay escalation may be mitigated by holding agencies accountable for managing-to-budget.

- *Hiring Methods*: There are some 400 authorities for hiring competitive employees. This proliferation is an administrative burden for personnel staff, and unduly complicates personnel and pay systems, and personnel reporting. Reduce the number of hiring methods to three; *e.g*., (1) permanent; (2) temporary, indefinite with benefits; and, (3) temporary, time and benefits limited.

- *Recruitment Incentive Authorities*: Agencies currently have authority to offer recruitment, retention and relocation bonuses in certain situations. We need to allow recruitment bonuses for current Federal employees in certain situations; review the rationale for prohibiting allowances for employees with job offers at the same or different agencies; and permit flexibility in methods of incentive payment. (Currently the payment is lump sum)

A second area for action is the lack of tools to re-shape the workforce. Some skills surpluses or shortages can be met through training and development. Others can not. However, not having the authority to offer buyouts without loss of positions or to offer early retirement unless a reduction in force is imminent limits our flexibility to manage the workforce.

We need the authority to use voluntary separation incentives and early retirement authority to reshape the workforce without the penalty of losing ceiling or waiting until reduction in force is in the offing. We believe that these authorities, if used in the context of a documented workforce transition plan, would greatly improve our ability to re-shape and effectively manage the workforce.

6. Where has the agency successfully delegated authority or restructured to reduce the number of layers that a programmatic action passes through before it reaches an authoritative decision point (e.g. procuring new computers, allocating operating budgets, completely satisfying a customer's complaint, processing a benefits claim, and clearing controlled correspondence)? Where can the agency improve its processes to reduce the number of layers that a programmatic action passes through before it reaches an authoritative decision point? Please provide two examples of each.

HHS has taken a number of actions to delayer and restructure operations to improve customer service and decision-making. The most publicized of these initiatives is the initiative to reform the Medicare and Medicaid Agency, changing the name of the Health Care Financing Administration to the Centers for Medicare and Medicaid Services. The aim of the changes is to make quality service the number one priority in the new CMS by restructuring the agency around three centers that reflect the major lines of business.

HHS is leading the Federal government-wide effort to design and implement a streamlined, simplified grants process. At the heart of this effort is development of a single source for the public to find federal grant opportunities, apply for grants, then manage and report on the use of grant funds. The users of the system – both Federal agency grants and program staff and grantees – will determine the requirements for the streamlined, simplified grants process. Making this work will require a variety of skills including project management, information technology, contractual and legal support.

In an effort to speed up the process of buying necessary equipment, NIH set up an electronic catalog, ordering, and accounting system. Last year, this system logged over 12,000 orders and with substantial savings on each transaction.

On June 14 the Secretary announced the decision to move to a unified financial management system for the Department. This effort will result in the Department having two modern accounting systems: one for CMS and its Medicare contractors, and one serving the rest of the Department. The consolidation will eliminate duplication of functions, provide better service delivery, and provide uniform, integrated financial information for all of HHS.

An initiative is underway to consolidate administrative functions across the staff divisions of the Office of the Secretary, providing economies of scale and better service to managers and staff. The consolidated administrative office is to become functional at the beginning of FY 2002. The details of how this will affect our workforce will be included in our restructuring plan in September.

We are taking steps to consolidate personnel offices across HHS. Instead of having separate personnel offices for each Operating Division, smaller OPDIVs will receive services from a single, consolidated office. We expect this to provide economies of scale by reducing duplication of staffing. At the same time, the broader span of service should provide the opportunity for employees to develop more specialized knowledge in certain areas so they can provide better service. We are in the process of consolidating personnel offices in SAMHSA and AHRQ to receive personnel services from the Program Support Center. We are also looking at ways to consolidate the multiple personnel offices in large OPDIVs such as NIH and FDA to provide comparable savings by eliminating duplicate offices.

While these initiatives are underway on a Departmental basis, several of the Operating Divisions are taking steps to move decision-making closer to the people they serve.

The Administration for Children and Families functionally consolidated its 10 regional offices into five hubs to reduce duplication and improve service delivery. The Hubs share resources and expertise across Hub and regional offices in a manner that results in improved outcomes for children and families and cost-efficient service delivery.

ACF also delegated certain program and administrative activities to regional offices, so that Regional Hub Directors and Regional Administrators have the authority to review and approve State plans and amendments for mandatory grants and to authorize grant awards for some discretionary programs.

In a similar action, the Administration on Aging delegated authority from the Assistant Secretary to Regional Administrators to approve State plans. They also streamlined the process for routine grant action to reduce the levels of approval necessary to make awards. This involved delegating authority from the Assistant Secretary to the chief program, budget and grants management officials within the agency.

At the beginning of FY 2001, FDA's Office of Financial Management encouraged its Centers to consolidate recurring charges for items such as copier paper, GPO Printing, graphics, motorpool, refurbished furniture, Fedex and others. Consolidation has reduced the number of financial documents for these recurring charges from approximately 450 - 600 in previous years to less than 100 in FY 2001. The number of yearly transactions being entered into the accounting system have been reduced from approximately 10,500 in FY 2000 to a projected 3,000 entries for FY 2001 with a corresponding saving in time and resources to provide service and track expenditures. More improvements are in process or being planned.

SAMHSA is actively working to streamline the discretionary and mandatory grant processes by reducing layers of review, simplifying processes, systematic planning, expanding shared databases, and strategic use of contractor support. The goal is a more responsive, less cumbersome process for awarding grants.

The Program Support Center is also implementing a new personnel system. When implemented, this system will reduce processing requirements and move data input to the lowest level by allowing mangers and employees to access the system for certain actions.

7. What barriers (statutory, administrative, physical, or cultural) has the agency identified to achieve workforce restructuring?

We discussed earlier some statutory / regulatory barriers to workforce restructuring.

A significant organizational / cultural barrier to workforce restructuring is a lack of experience in conducting and implementing workforce planning. While the concepts of workforce planning are easy to understand, putting them into practice has proven, not just in HHS but across government, to be more difficult. We are convinced that in HHS we have worked through the difficulties and are about to emerge from planning to having operational workforce plans.

A corresponding cultural barrier to workforce restructuring is getting beyond the question of just what is the right number of employees to addressing the issue of what are the right skills in the workforce. The right number is easily quantified. The right skills are more difficult to assess – both in terms of what they should be and their presence in the workforce. If program success is measured by achieving goals and providing customer service, the skills of our employees, not just the numbers must be the determining factor.